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New Drug Law's Cost Impact Debated

Some Question Whether Insurance Companies Will Get Lower Prices

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As lawmakers squabble over just how much the new Medicare prescription drug package will cost, a team of government auditors in Philadelphia knows one thing: If history is any guide, it won't be a good deal for seniors or taxpayers.

Year after year, for more than a decade, bureaucrats have been spitting out reports detailing "excessive overpayments" by Medicare for the limited number of drugs that the program covered, and laid out how the government could have cut those costs in half by using its purchasing power to negotiate lower prices, the way the Department of Veterans Affairs does.

Historically, Medicare covered only medicines, such as cancer chemotherapy, given in a hospital or administered directly by a physician. Last fall, Congress added a broad prescription drug benefit that covers outpatient medication, a major change that dramatically raised the financial stakes.

Under the earlier, limited drug program, the Office of the Inspector General at the Department of Health and Human Services began sounding the alarm in 1998, identifying what it called $1 billion in overpayment that year for 34 drugs. For three medications, Medicare paid 16 times more than the VA, the analysts wrote.

A year later, taxpayers were paying even more. "Medicare and its beneficiaries would save $1.6 billion a year if 24 drugs were reimbursed at amounts available to the VA," wrote the IG team based in Philadelphia. Last year, for example, Medicare's cost for the asthma treatment albuterol was 47 cents a milligram, while the VA was paying 5 cents a milligram.

Because the federal government and beneficiaries share Medicare costs, taxpayers and senior citizens were hit by the higher prices. By the time two congressional panels decided to investigate in 2001, the price gap was nearly $2 billion -- $380 million of that in higher co-payments by elderly patients. When Deputy Inspector General George F. Grob was called to testify, he could barely conceal his frustration.

"So every day, every month, every period that we don't solve the problem, the problem gets bigger, and the Medicare expenditures rise," Grob told the lawmakers in his written testimony.

Now, the whopping figures tallied by his team have become a critical piece of ammunition in the debate over the new Medicare benefit intended to help America's seniors afford life-saving medicines.

There remains sharp disagreement over how the new drug coverage should be run and whether it is better to have the government use its clout to bargain over prices or turn the negotiating over to private

companies.

The new law, which goes into full effect in 2006, will provide optional coverage for the vast majority of medications generally purchased at a pharmacy. Participants will be able to choose which insurance package they wish to buy, with subsidies provided to low-income seniors, and the Bush administration predicts that private companies administering the benefit will negotiate discounted prices as they compete to sign up the elderly.

Over the years that Medicare provided only a limited drug benefit, the inspector general's office was not the only place to remark on the gap between what the VA and Medicare paid for drugs. Another is the General Accounting Office, the investigative arm of Congress, where Comptroller General David M. Walker's staff documented excessively high drug costs and has long recommended that Medicare and other government programs follow the VA model, leveraging its purchasing power for lower prices.

During the debate over the new Medicare drug benefit, however, lawmakers, led by the Bush White House, added a provision that rejected the tack advocated by Grob, Walker and the dozens of auditors who have tracked the rise of Medicare spending. Rather than adopt the VA model, the new law explicitly prohibits the government from negotiating with drugmakers.

Sen. John McCain (R-Ariz.) calls the prohibition "a living, breathing testimonial to the political influence of the pharmaceutical companies" by preventing "Medicare from doing exactly what the VA has been doing: saving hundreds of millions of dollars."

If the government did use its bargaining power on behalf of all 41 million Medicare recipients, "it would drive down prices for Medicare first and eventually across the board," predicted Rep. Tom Allen (D-Maine).

Sen. Edward M. Kennedy (D-Mass.) and others have filed legislation to eliminate the ban on using the government's negotiating power, an approach endorsed by presumed Democratic presidential nominee John F. Kerry and the seniors group AARP.

"The single most irresponsible provision in the Medicare bill is the prohibition that prevents Medicare from negotiating lower-priced prescription drugs," Kennedy said in a statement. "The Bush administration pretends to protect senior citizens, but it's bilking them instead, by allowing pharmaceutical firms to charge such exorbitant prices."

Leslie Norwalk, acting deputy administrator of the Centers for Medicare and Medicaid Services (CMS), agreed that the federal government "does not have a very good track record" on Medicare drug prices. But the solution, she argued, is not a greater government role.

By letting the private sector -- insurance companies and pharmacy benefit managers who administer drug benefits for insurers -- run the program, Medicare should benefit from seasoned private sector negotiators, she said.

The Congressional Budget Office agreed in its analysis that the private plans administering the new Medicare benefits "will have strong incentives to negotiate price discounts."

When the new law is implemented in 2006, "I am confident that beneficiaries will get prices similar to those we see in the commercial market," Norwalk said. "The same companies that are negotiating on behalf of senators, congressmen and Cabinet secretaries will also be negotiating on behalf of Medicare

beneficiaries."

But that, Allen said, is the problem. If Medicare intends to give seniors health benefits similar to what federal employees receive -- as Norwalk suggested -- taxpayers would need to pour even larger subsidies into the program. And if Medicare follows the route of the private sector, get ready for double-digit premium increases, he warned.

"We are moving Medicare toward a private insurance program," he said. "But it's not clear whether we are moving toward the federal employees' model or the kind of insurance small businesses are struggling with today."

Stephen W. Schondelmeyer, director of the University of Minnesota's Pharmaceutical Research in Management and Economics Institute, cautioned that in the past, pharmacy benefit companies have been "more strongly aligned with the drug companies than their clients," and there is little reason to expect that will change with Medicare.

Administration officials and many conservative thinkers argue that if Medicare negotiated directly with drug manufacturers, it would amount to a government monopoly and a system of price controls. Citing the energy crisis of the 1970s, James Pinkerton, a fellow at the New America Foundation, predicts the approach would lead to drug shortages and sharp cutbacks in pharmaceutical research.

The other side counters that Medicare recipients, expected to consume $1.6 trillion worth of medication over the next decade, would be a major player but not a monopoly in a marketplace estimated at $4.6 trillion.

"Medicare would have a major impact" on the market, Walker said. "That doesn't mean it's wrong."

Prescriptions bought by the VA for its 4 million beneficiaries cost at least 24 percent less than the average retail price, said Steve Thomas, director of the program. For many drugs, however, the VA negotiated price is on average 40 percent less that what most consumers pay, Thomas said.

The VA program has proven so popular it was extended to active-duty military and the U.S. Public Health Service, but efforts to open it up further met with "institutional resistance within the VA," Walker said. "They negotiate such a good deal," he said, that if others attempted to take advantage of it, drug companies might end up charging the VA more.

Asked if it would be possible for Medicare to adopt the VA model, Thomas said he could not comment. "I was told not to," he said.

But Walker said policymakers "need to do things in the collective best interest. That's how you get a better deal for taxpayers."

Still, the VA and Medicare do differ in significant aspects. Historically, Medicare has provided retirees with broad options, such as the ability to choose their own doctors or purchase any medicine prescribed for a particular ailment.

The VA, on the other hand, "is a government-run, government-operated system" that limits patient choices, Mark B. McClellan, the new CMS chief, said in a congressional hearing. Doctors and hospitals are told which medications are covered by the VA, based on a formulary or preferred drug list.

"It's one set of drugs that are on formulary and others that aren't covered, and that's what leads to some of their strong negotiating power," he said.